South Carolina
Department of Insurance
Division of Financial Services
1201 Main Street, Suite 1000
Columbia, S.C. 29201

MARK SANFORD
Governor

SCOTT H. RICHARDSON CPCU
Director of Insurance

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General Qualifying Requirements and Application Procedures For a Domestic Health Maintenance Organization (HMO)

Instructions:

1. The HMO should address all sections and subsections outlined below. If any section or subsection does not apply, a clear explanation of why it does not apply should be provided.

2. All sections and subsections should be tabbed and clearly labeled to correspond to the titles of the sections and subsections of this document (e.g., I. General Qualifying Requirements, A. Medicare Advantage).

3. One copy of the application should be directed to the attention of Tim Campbell, Chief Financial Analyst, South Carolina Department of Insurance, 1201 Main Street, Suite 1000, Columbia, SC 29201 or Post Office Box 100105, Columbia, SC 29202-3105. Phone: 803-737-6109. E-mail: tcampbell@doi.sc.gov. Note: Do not send a partial or incomplete application as it will be returned.

4. After an analysis of the application is completed and the application is approved for licensure by the Director of Insurance, the HMO will then be notified:

   A. To deposit acceptable securities pursuant to S.C. Code Ann. Section 38-33-130(A) (1976, as amended).

   B. That it must not commence business until an on-site examination of its processes and procedures has been conducted by the Department's Office of Financial Examinations.

S.C. Code Ann. Section 38-33-170(B) provides for the Director to make an examination concerning the quality of health care services of an HMO as often as reasonably necessary for the protection of the citizens of this State, but not less frequently than once every three years. To comply with the provisions of the Code, each HMO licensed in South Carolina must comply with the following:

> The HMO must have a "Quality Assurance Review" performed within three years of the issuance of a certificate of authority from the Department and at least once every three years thereafter. The "Quality Assurance Review" must be performed by a qualified organization performing audits based upon criteria similar to those set forth

in the National Committee for Quality Assurance (NCQA) guidelines. The HMO will be responsible for the selection of a qualified organization to perform the review and the costs associated with the review as provided for in S.C. Code Ann. Section 38-33-170(D). All "Quality Assurance Review" reports must be submitted to the Department upon completion. Records supporting the findings in the report must be maintained at the HMO's principal place of business.

I. General Qualifying Requirement

Outlined below are the general requirements to be met by a domestic health maintenance organization to qualify for a license to transact business in South Carolina. Reference should be made to Title 38, Chapter 33 and Regulation 69-22 of the South Carolina Code of Laws.

Provider-Sponsored Organizations (PSOs) seeking to contract with the Health Care Financing Administration (HCFA) for the provision of health care services through Medicare Advantage are required to seek licensure as HMOs in the State of South Carolina. This application is to be used by PSOs for that purpose.

NOTE: Pursuant to S.C. Code Ann. Section 38-33-250, all applications and filings required under S.C. Code Ann. Section 38-33-30 and any annual and quarterly financial reports required under S.C. Code Ann. Section 38-33-90 must be treated as public documents. Nothing herein may be construed to require disclosure of trade secrets, privileged or confidential commercial information, or replies to a specific request for information made by the Director. Information deemed by the HMO to be confidential pursuant to this section should be stamped **"CONFIDENTIAL,"** and reasons for doing so provided at the front of the application. The Department of Insurance will make the final determination as to which information, if any, may be exempt from disclosure.

Please address all sections.

A. Medicare Advantage

1. Do you plan to offer health care services through Medicare Advantage? If yes, do you plan to offer any other products? Please explain.

2. Are you structured as a PSO?

B. Net Worth

No health maintenance organization may be issued a certificate of authority unless it is possessed of net worth of at least one million two hundred thousand dollars, six hundred thousand dollars of which must be capital if it is a stock health maintenance organization. The Director may require a health maintenance organization to meet greater initial net worth requirements based on the health maintenance organization's plan of operation. See S.C. Code Ann. Section 38-33-100. The HMO must provide a current balance sheet.

C. Securities Valuation

Pursuant to Title 38, Chapter 12 of the South Carolina Code of Laws, securities appearing in Schedule D of the HMO's most recent annual statement must be valued by the NAIC Securities Valuation Office, or proper evidence must be provided to this Department to indicate that those securities not listed have been submitted to the NAIC Securities Valuation Office for valuation before the application is submitted to this Department. The HMO must provide a statement indicating that securities have been valued or submitted for valuation, with supporting documentation.

D. Organizational Examination

An organizational examination conducted by the Office of Financial Examinations of the Department must be completed prior to the issuance of a certificate of authority to the HMO.

E. Place of Business

No health maintenance organization organized, chartered and existing under the laws of this State will be licensed by the Director unless it maintains its principal place of business and primary executive, administrative, and home offices and all original books and records of the organization in this State. See S.C. Code Ann. Section 38-5-80(k).

The HMO must provide a statement indicating that it will comply with all the requirements of S.C. Code Ann. Section 38-5-80(k). Provide the name of the city in South Carolina where the home office will be located. Describe the space leased or purchased, or plans to build office space. Describe any plans for economic development in South Carolina, such as satellite offices, claims processing, office buildings, etc. Describe the positions to be located at the home office and the functions to be performed there (typically CEO, CFO, member services, marketing, claims processing, support, etc.). Describe how claims will be processed; if processed "on line," explain who at the home office will be able to access the data immediately and print hard copies. Indicate if all books and records will be maintained, as required, at the home office. Indicate if the original claims register will be maintained at the home office, as required. An HMO desiring to move business records or operations outside of the State, or to initially keep business records or operations outside of the State, shall apply to the director or his designee for approval to do so. The application process has been set out in the Department's Bulletin 2002-08. Please review the Bulletin at: https://www.doi.sc.gov/Eng/Public/bulletins/Bulletin2002-08.pdf and file the required information with the application.

F. Use of Name

The HMO's use of a name which is similar to that of any active health maintenance organization previously licensed in this State could be contrary to the public interest. See S.C. Code Ann. Section 38-33-40(A)(6). The HMO must provide a statement indicating that the HMO is aware of and meets the requirements of S.C. Code Ann. Section 38-33-40(A)(6).

If the HMO meets all general qualifying requirements, please continue with this application.

II. Specific Requirements

A. Cover Letter

A cover letter containing the following language:

_____, President and _____, Chief Financial Officer being duly sworn, each deposes and says that they are the above described officers of the HMO, and that the information and statements accompanying this application are true and correct according to the best of their information, knowledge and belief, respectively.

By:_____ _____
President Date

By:_____ _____
Chief Financial Officer Date

_____

Name of HMO

SUBSCRIBED AND SWORN TO BEFORE ME THIS
_____DAY OF _____, 20____.
NOTARY PUBLIC, STATE OF_____.
MY COMMISSION EXPIRES_____.

B. Application Fee
A check made payable to the South Carolina Department of Insurance in the amount of two thousand dollars ($2,000.00) for filing an application for a certificate of authority as required by S.C. Code Ann. Section 38-33-220(A)(1). The fee is non-refundable.

C. Registration of Business
Evidence that the HMO is registered with the Secretary of State of South Carolina to do business in this State.

D. Affidavit of Compliance
Please use attached Form No. 1008.

E. Appointment to Accept Service
Appointment of the Director of Insurance of South Carolina as its Attorney to Accept Service. Use attached Form SCID Number 1027 HMO.

F. Disclosure of Ownership
The HMO must disclose the names of all principal owners, including a parent corporation, if any.

G. Organizational Documents
A copy of the organizational documents of the HMO, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments.

H. Bylaws and Charter
Copies of the HMO's original Bylaws and Charter and all subsequent amendments to either.

I. Biographical Affidavit
A biographical affidavit for each person who is to be responsible for the management and conduct of the affairs of the HMO including, but not limited to, all members of the board of directors, board of trustees, executive committee or other governing board or committee. Use attached SCID Form 1000B and photocopy, as needed, or use the NAIC Biographical Affidavit at: http://www.naic.org/documents/industry_ucaa_form11.doc

J. Contracts Between Management and HMO
A copy of any contract made or to be made between any providers or persons listed in F. above and the HMO.

K. Audited Financial Report
An audited financial report, as of the most recent December 31, prepared by a Certified

Public Accountant for the controlling entity or individual.

L. Forms 10K and 10Q
Copies of Forms 10K and 10Q if the ultimate parent is required to file these reports with the Federal Securities and Exchange Commission. If not required, please explain.

M. Working Capital
A statement as to its sources of working capital as well as any other sources of funding.

N. Pro Formas
A three-year Plan of Operation and pro formas. Use NAIC UCAA Form 13 - Pro Forma Financial Statements (Life/Health Companies) which can be accessed at: http://www.naic.org/documents/industry_ucaa_form13L.xls.should clearly show sources of revenue (i.e.: commercial enrollment, Medicare, TPA, etc.).

O. Premium to New Worth Calculation
Estimated premium to net worth ratios for each of the next three years.

P. Reinsurance and Stop-Loss
All contracts of reinsurance or a summary of the plan of self-insurance as required by S.C. Code Ann. Section 38-33-30(D) and a copy of a policy of individual excess stop-loss coverage provided by an insurance company licensed in this State as required by S.C. Code Ann. Section 38-33-130(C). The policy must include provisions to cover all incurred, unpaid claim liability in the event of the HMO's termination due to insolvency or otherwise. In addition, the policy must provide that the insurer will issue an individual conversion policy to any enrollee upon termination of the HMO or the enrollee's ineligibility for further coverage in the HMO.

Q. Group Contract
A copy of the form or group contract, if any, which is to be issued to employers, unions, trustees, or other organizations.

R. Counties to be Served
A statement reasonably describing the counties to be served.

S. Provider Access Map and Travel to Providers
The HMO should provide a map of the entire service area which shows the location of hospital, emergency room, specialist and primary care providers. This should be accompanied by estimated maximum travel time and distance for each county of operation.

T. Membership/Provider Estimates and Ratio
Projected membership and projected member/provider ratios in each county as of December 31 for each of the next three years.

U. List of Providers
List names and addresses of each provider by county and type, including hospital, primary care, specialist and emergency room. The HMO must submit letters of intent for all

proposed participating providers, including any individual members of a group practice who will participate in the HMO. See W. below.

V. Sanctioned Providers- HMOs Enrolling Medicare Members

Statement affirming that no providers have been sanctioned or terminated by Medicare. If not applicable, so state.

W. Provider Contracts

A specimen of the provider contract to be entered into with each type of health care provider. S.C. Code Ann. 38-33-40(B) states that no health maintenance organization may be licensed unless it has employed, contracted with or made arrangements satisfactory to the director or his designee with both physicians and hospitals to participate as providers in each geographic area to be served. In the case of a group practice such as an individual practice association, provider-hospital association, or any other group of providers, this requirement may be met in any of the following ways:

1. Complete, detailed stand-alone individual contracts signed by all participating providers in the group (physicians, hospitals, etc.), with no master contract with the practice administrator or similar person.

2. A master contract signed by the practice administrator or similar person on behalf of the group, along with complete, detailed stand-alone individual contracts signed by all participating providers in the group (physicians, hospitals, etc.).

3. A master contract signed by the practice administrator or similar person on behalf of the group, along with individual abbreviated agreements signed by each participating provider and attached to the master contract. These agreements would be attached to the master contract. These agreements must, at a minimum, state that the provider agrees to all the requirements set forth in the master contract.

X. Form SCID 505

A statement which affirms that the HMO will receive an executed Form SCID 505 (copy attached) 1) from each provider listed in U. above with whom the HMO enters into a contract, 2) from an "employing entity" on behalf of all the employing entity's providers [See S.C. Code Ann. Section 38-33-20(4) (2002)], or 3) in the case of a group agreement (IPA, hospital, clinic, etc.), from the administrator or other authorized individual authorized to execute the provider contract, which must contain language which clearly states that the group's participating providers are prohibited from billing members (enrollees) in the event of insolvency of the HMO.

Y. Authorization and Referral

Description of how services will be authorized and coordinated, including out of plan (fee-for-service) medical services; and proposed referral authorization form.

Z. Marketing - Commercial

A description of the HMO's proposed method of marketing; a description of its proposed method of training and supervising its marketing representatives; and an example of its proposed marketing brochure.

AA. Marketing - Medicare
A description of the HMO's proposed method of marketing; a description of its proposed method of training and supervising its marketing representatives; and an example of its proposed marketing brochure.

AB. Personnel and Office Space
A breakdown of personnel and office space sufficient to handle the administration of the HMO's business in the counties it is to serve.

AC. Claims Processing
A detailed description of the claims processing and payment procedures, including the capacity to file claims and track referrals for out of plan services.

AD. Enrollment Forms and Process - Commercial
Proposed commercial member enrollment forms and procedures.

AE. Enrollment Forms and Process - Medicare
Proposed Medicare member enrollment forms and procedures.

AF. Evidence of Coverage - Commercial
A copy of the form of evidence of coverage to be issued to the commercial enrollees.

AG. Evidence of Coverage - Medicare
A copy of the form of evidence of coverage to be issued to the Medicare enrollees.

AH. Disenrollment Forms and Process - Commercial
Proposed commercial member disenrollment form and procedures.

AI. Disenrollment Forms and Process - Medicare
Proposed Medicare member disenrollment form and procedures.

AJ. Disenrollment Letter - Commercial
Proposed letter informing member of disenrollment.

AK. Disenrollment Letter - Medicare
Proposed letter informing member of disenrollment.

AL. Continuation
Description of continuation policy and procedures.

AM. Complaint Procedures
A description of the complaint procedures to be utilized as required under S.C. Code Ann. Section 38-33-110.

AN. Quality of Healthcare
A description of the procedures and programs to be implemented to meet the quality of health care requirements in S.C. Code Ann. Section 38-33-40.

AO. Record Keeping

Description of the record keeping system, including retention of records to meet federal contract requirements.

AP. Reporting

Example of the type of reports to be maintained for internal and external use, including reports for providers.

AQ. Member Participation in Policy and Operation

A description of the mechanism by which enrollees have an opportunity to participate in matters of policy and operation under S.C. Code Ann. Section 38-33-60(B).

Attachments

1. Form SCID No. 1008
2. Form SCID No. 1027 HMO
3. Form SCID No. 1000B
4. Form SCID No. 505

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Form 1008

AFFIDAVIT OF COMPLIANCE

STATE OF_____

Personally appeared _____

who being duly sworn, says he is the _____
(President or Chief Executive Officer)

of (Name of Company) _____
that the said Company has not violated any of the laws of the State of South Carolina and that it accepts the terms and obligations imposed by the laws of the State as a part of the consideration for the issuance to it by the Director of Insurance of said State of a license to do business in said State.

_____
(Signature of President or Chief Executive Officer)

Sworn to before me this the _____

day of _____, 20 _____

_____ (SEAL)

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SCID Form 1027 HMO

APPOINTMENT OF ATTORNEY TO ACCEPT SERVICE

The _____, a Health Maintenance Organization

(HMO) duly organized under the laws of the State of _____, appoints the Director of Insurance of the State of South Carolina, and his or her successors in office, to be its lawful attorney upon whom all legal process in any action or proceeding against it shall be served and further agrees that any lawful process against it which is served upon this attorney shall have the same legal validity as if served personally upon the HMO.
The HMO gives the Director of Insurance and his or her successors, full authority to do every act necessary to be done under this appointment as fully as the HMO could do if personally present, and ratifies all that the Director of Insurance shall lawfully do under the power granted by this appointment. This authority may be withdrawn only upon a written notice of revocation and in any case shall continue in effect so long as any liability arising out of this appointment remains outstanding in the State.

The HMO designates _____whose address is

_____ as the person to whom process against the HMO served upon the Director shall be forwarded.
IN WITNESS OF THIS APPOINTMENT, the HMO, pursuant to a resolution duly adopted by its Board of Directors, has caused this instrument to be executed in its name by its President and Secretary, and its corporate seal to be affixed

to it at the City of _____, State of _____, this _____ day of

_____, 20____.

Attest:

_____ _____
President Name of HMO

_____ _____
Secretary Name of HMO

STATE OF _____)

COUNTY OF _____)

This certifies that on the _____ day of _____, 20_____, before the undersigned

Notary Public in and for the said County and State, personally appeared the above-named _____

_____, known to me to be the President, and _____

_____, known to me to be the Secretary of _____,
the HMO mentioned in and which executed the foregoing power of attorney, and severally acknowledged that they executed the same by authority and in behalf of said HMO, pursuant to a resolution of the Board of

Directors of said HMO duly adopted on the _____ day of_____, 20_____; and

_____, the Secretary of said HMO, further acknowledged that the corporate seal thereto attached and impressed therein is the corporate seal of said HMO and was affixed thereto by him.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affix my seal this _____ day of

_____, 20_____.

Notary Public _____ (L.S.)

State of _____

My Commission Expires:_____(Seal)

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names). _____

_____

_____

_____

Type of entity (i.e. insurance company, premium finance company, etc.):_____

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). _____

   b. Maiden Name (if applicable).____

2. a. Have you ever had your name changed? If yes, give the reason for the change and provide the full name(s).

   _____

   _____

   _____

   b. Other names used at any time (including aliases).

   _____

   _____

3. a. Are you a citizen of the United States?

   b. Are you a citizen of any other country, if so, what country?

4. Affiant's Occupation or Profession. _____

5. Affiant's business address. _____

   Business telephone. _____

6. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained

Graduate Studies:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained

Other Training:

Name	City/ State	Dates Attended (MM/YY)	Certification Obtained

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information)

7. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association

8. Present or proposed position with the HMO entity. _____

_____

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient.

Beginning/Ending Dates (MM/YY) _____
Employers' Name _____

Address _____City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Fax _____

Offices/Positions Held _____Supervisor / Contact _____

Beginning/Ending Dates (MM/YY) _____

Employers' Name _____

Address _____City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Fax _____

Offices/Positions Held _____ Supervisor / Contact _____

Beginning/Ending Dates (MM/YY) _____
Employers' Name _____

Address _____City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Fax _____

Offices/Positions Held _____ Supervisor / Contact _____

Beginning/Ending Dates (MM/YY) _____
Employers' Name _____

Address _____City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Fax _____

Offices/Positions Held _____ Supervisor / Contact _____

10. a. Have you ever been in a position which required a fidelity bond? _____ If any claims were made on the bond, give details. _____
_____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. _____
_____

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

Organization/Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known _____

Organization /Issuer of License _____ Address _____

City _____ State/Province _____ Country _____Postal Code _____

License Type _____License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

_____

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

_____

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? _____

_____

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? _

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

_____

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? _____

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? _____

_____

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? _____

i. Had a finding made by the Comptroller of any state or the Federal Government that you have

violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? _____

j. Had a lien, or foreclosure action filed against you or any entity while you were associated with that entity?

_____

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

_____

_____

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. _____

_____

_____

If any of the stock is pledged or hypothecated in any way, give details. _____

_____

14. Will you or members of your immediate family subscribe to or own, beneficially or of record, shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

_____

_____

If any of the shares of stock are pledged or hypothecated in any way, give details.

_____

_____

15. Have you ever been adjudged a bankrupt? _____

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or

Governmental-licensing agency? _____

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? _____
_____

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____ at I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

_____ _____
(Signature of Affiant) Date

This document was executed and signed in the presence of the following witnesses:

1. _____ 2. _____

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ of _____, 20___

By _____, and:

_____ who is personally known to me, or

_____ who produced the following identification:

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

_____

_____

_____

1. a. Affiant's Full Name (Initials Not Acceptable). _____

   b. Maiden Name (if applicable) _____

2. Affiant's Social Security Number _____

3. Government Identification Number if not a U.S. Citizen _____

4. Foreign Student ID# (if applicable) _____

5. Date of Birth: (MM/DD/YY) _____Place of Birth: City _____
   State/Province _____Country _____

6. Name of Affiant's Spouse (if applicable) _____

7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code

Dated and signed this _____day of _____ at _____

I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

_____ _____

(Signature of Affiant) Date

This document was executed and signed in the presence of the following witnesses:

1. _____ 2. _____

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____Day of _____Month,

20_____ By _____, and:

☐ who is personally known to me, or

☐ who produced the following identification:

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

South Carolina
Department of Insurance
Division of Financial Services
1201 Main Street, Suite 1000
Columbia, S.C. 29201

MARK SANFORD
Governor

SCOTT H. RICHARDSON CPCU
Director of Insurance

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HOLD HARMLESS AGREEMENT

In accordance with the requirements of S.C. Code Ann. Section 38-33-130 (B) (2002), and as a condition of participation as a health care provider in_____ _____ (hereinafter the "HMO"), the undersigned Provider (hereinafter "Provider") hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees of the HMO or persons acting on their behalf, for health care services which are rendered to such enrollees by Provider, and which are covered benefits under enrollees' evidence of coverage. This agreement extends to all covered health care services furnished to the enrollee during the time he is enrolled in, or otherwise entitled to benefits promised by the HMO. This agreement further applies in all circumstances including, but not limited to, non-payment by the HMO and insolvency of the HMO.

This agreement shall not prohibit collection of copayments from enrollees by Provider in accordance with the terms of the evidence of coverage issued by the HMO. The Provider further agrees that this agreement shall be construed to be for the benefit of enrollees of the HMO and that this agreement supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and such enrollees, or persons acting on their behalf.

Provider's Name: _____
(Please type)

Signature: _____

Title (if applicable): _____

Date: _____